

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

CASE TRANSFER

CLIENT'S INFORMATION

INDIVIDUAL'S NAME <i>(Last, First, M.I.)</i>	ASSISTS ID	DATE OF BIRTH	
ADDRESS <i>(No., Street, City, State, ZIP)</i>	AREA CODE AND PHONE NO.	PRIMARY LANGUAGE	
TRANSFER SUPPORT COORDINATOR/SUPERVISOR	SITE CODE	WORKER ID NO.	DATE TRANSFER
RECEIVING SUPPORT COORDINATOR/SUPERVISOR	SITE CODE	WORKER ID NO.	DATE RECEIVED

RECEIVING SUPPORT COORDINATOR/SUPERVISOR:

Update ASSISTS Worker ID/Office ID ☐ Yes ☐ NoUpdate Support Coordinator in RIMS *(Verify Client Information Screen)* ☐ Yes ☐ No

ELIGIBILITY

ALTCs Eligibility: <input type="checkbox"/> Eligible <input type="checkbox"/> State ONLY Eligibility <input type="checkbox"/> Application Pending	DDD DIAGNOSIS
Targeted Support Coordination <input type="checkbox"/> Yes <input type="checkbox"/> No	Type: _____ Frequency: _____
Division Development Disabilities Re-determination completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending <input type="checkbox"/> N/A	

CURRENT SERVICES/PROGRAMS

RESIDENTIAL	ADDRESS <i>(No., Street, City, State, ZIP)</i>	AREA CODE AND PHONE NO.
DAY PROGRAM	ADDRESS <i>(No., Street, City, State, ZIP)</i>	AREA CODE AND PHONE NO.
EMPLOYER	ADDRESS <i>(No., Street, City, State, ZIP)</i>	AREA CODE AND PHONE NO.
SCHOOL	ADDRESS <i>(No., Street, City, State, ZIP)</i>	AREA CODE AND PHONE NO.

Other Residential Placement for Educational Reasons (A.R.S. 15): ☐ Yes ☐ No

PRESENT SITUATION

☐ Stable
☐ Unstable Explain: _____

Any open UIR's / IR's on RIMS? <input type="checkbox"/> Yes <input type="checkbox"/> No	REPORT NO.(S)
Follow-up Needed <i>(Including referrals, DME, Aug Com, etc.)</i>	

DATE OF LAST ISP	DATE OF LAST QUARTERLY REVIEW	DATE OF LAST QBHP REVIEW
QBHP's NAME <i>(First, Middle, Last)</i>		

Behavior Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Program Review Committee involved? <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE OF LAST PRC REVIEW
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Medications? ☐ Yes ☐ NoIf yes, does the individual have sufficient medications to last until next doctor's appointment? ☐ Yes ☐ NoOther Agencies Involved: *(e.g. APS, CPS, CRS, RHBA, Public Fiduciary, Tribal, Law Enforcement, etc.)*

INDIVIDUAL'S NAME <i>(Last, First, M.I.)</i>	ASSISTS ID	DATE OF BIRTH
CHECKLIST		
Client/Family notified of transfer:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE COMPLETED
Transfer progress note completed:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE COMPLETED
ALTCS Change form:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE COMPLETED
Mailed to local ALTCS office	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE COMPLETED
Copy mailed to managed care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE COMPLETED
Regional Behavioral Health Authority notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE COMPLETED
Client primary record updated <i>(printed/filed)</i> :	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE COMPLETED
Significant other screen updated <i>(printed/filed)</i> :	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE COMPLETED
Benefits and evaluation screen updated <i>(printed/filed)</i> :	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE COMPLETED
Service plan screen updated <i>(printed/filed)</i> :	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE COMPLETED
DDD billing information form completed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE COMPLETED
For residential clients (DD-090):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE COMPLETED
Review current authorizations/scripts (ATF, CLS, SPP)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	DATE COMPLETED
ADDITIONAL INFORMATION		

Equal Opportunity Employer/Program

Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disability Act of 1990 (ADA), *Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975*, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program of activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at (602) 542-6825; TTY/TTD Services: 7-1-1.